FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040410

Facility Name: ELMWOOD CARE

Address: 7733 W. GRAND AVE (Number) ELMWOOD PARK (City) 60635 (Zip Code)

County: COOK

Telephone Number: (708) 452-9200 **Fax #** (708) 452-9294

IDPA ID Number: 363868389001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,883	2,632	6,593	39,108	8
9	SNF/PED					9
10	ICF	28,712	2,632	735	32,079	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,595	5,264	7,328	71,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.61%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 3,355

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	285,571	29,145	39,996	354,712		354,712	(25,349)	329,363			1
2	Food Purchase		307,501		307,501	(35,872)	271,629	(226)	271,403			2
3	Housekeeping	200,514	37,333		237,847		237,847	809	238,656			3
4	Laundry	62,216	32,307		94,523		94,523		94,523			4
5	Heat and Other Utilities			143,071	143,071		143,071	2,410	145,481			5
6	Maintenance	41,379	25,253	139,796	206,428		206,428	(41,946)	164,482			6
7	Other (specify):*							7,252	7,252			7
8	**TOTAL General Services**	589,680	431,539	322,863	1,344,082	(35,872)	1,308,210	(57,050)	1,251,160			8
	B. Health Care and Programs											
9	Medical Director			6,900	6,900		6,900		6,900			9
10	Nursing and Medical Records	2,283,540	212,931	247,163	2,743,634		2,743,634	(40,949)	2,702,685			10
10a	Therapy	80,247		15,197	95,444		95,444		95,444			10a
11	Activities	86,100	6,629	2,100	94,829		94,829		94,829			11
12	Social Services	64,132		5,393	69,525		69,525		69,525			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,946	3,946			15
16	**TOTAL Health Care and Programs**	2,514,019	219,560	276,753	3,010,332		3,010,332	(37,003)	2,973,329			16
	C. General Administration											
17	Administrative	139,910		505,693	645,603		645,603	(401,606)	243,997			17
18	Directors Fees											18
19	Professional Services			278,176	278,176	(39,539)	238,637	(151,189)	87,448			19
20	Dues, Fees, Subscriptions & Promotions			73,159	73,159		73,159	(26,475)	46,684			20
21	Clerical & General Office Expenses	91,456		169,035	260,491		260,491	(36,011)	224,480			21
22	Employee Benefits & Payroll Taxes			500,156	500,156	35,872	536,028	(8,373)	527,655			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,040	1,040		1,040	354	1,394			24
25	Other Admin. Staff Transportation			1,491	1,491		1,491	4,137	5,628			25
26	Insurance-Prop.Liab.Malpractice			108,927	108,927		108,927	1,254	110,181			26
27	Other (specify):*							33,592	33,592			27
28	**TOTAL General Administration**	231,366		1,637,677	1,869,043	(3,667)	1,865,376	(584,317)	1,281,060			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,335,065	651,099	2,237,293	6,223,457	(39,539)	6,183,918	(678,370)	5,505,548			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ELMWOOD CARE #0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			74,726	74,726		74,726	463,330	538,056			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,594	48,594		48,594	1,271,592	1,320,186			32
33	Real Estate Taxes			407,720	407,720	39,539	447,259	5,077	452,336			33
34	Rent-Facility & Grounds			1,564,605	1,564,605		1,564,605	(1,564,605)				34
35	Rent-Equipment & Vehicles			7,630	7,630		7,630	8,628	16,258			35
36	Other (specify):*							19,385	19,385			36
37	**TOTAL Ownership**			2,103,275	2,103,275	39,539	2,142,814	203,407	2,346,221			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,074	208,481	311,555		311,555		311,555			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,137	134,137		134,137		134,137			42
43	Other (specify):*							50,261	50,261			43
44	**TOTAL Special Cost Centers**		103,074	342,618	445,692		445,692	50,261	495,953			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,335,065	754,173	4,683,186	8,772,424		8,772,424	(424,702)	8,347,722			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	101,745	30		9
10	Interest and Other Investment Income	(92,213)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(226)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,951)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,302)	20		28
29	Other-Attach Schedule	(111,921)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (213,868)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(210,834)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (210,834)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (424,702)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ELMWOOD CARE

ID# 0040410

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty	$ (132)	10	1
2	Prior Year Legal Exp	(677)	19	2
3	Legal Expense-Collections	(1,355)	19	3
4	Legal Expense-Non Allowable	(38,807)	19	4
5	Veterans Expenses	(13,489)	10	5
6	Trust Fees	(150)	20	6
7	COPE Contribution - ICLTC	(4,306)	17	7
8	Contributions/Charitable	(885)	20	8
9	Promotions	(14,431)	20	9
10	Capitalized R&M	(19,516)	6	10
11	Seminar Expense - 2002 Seminar	(90)	24	11
12	FY2001-Amort R&M	1,643	6	12
13	Employee Benefits-(Non Allowable)	(8,373)	22	13
14	Legal Expense - Non Allowable	(11,353)	19	14
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(25,349)							(25,349)	1
2	Food Purchase	(226)											(226)	2
3	Housekeeping			809									809	3
4	Laundry													4
5	Heat and Other Utilities			976	1,434								2,410	5
6	Maintenance	(17,873)		724	(15,021)	(9,776)							(41,946)	6
7	Other (specify):*				778	6,474							7,252	7
8	**TOTAL General Services**	(18,099)		2,509	(12,809)	(28,651)							(57,050)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(13,621)			(27,328)								(40,949)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,946								3,946	15
16	**TOTAL Health Care and Programs**	(13,621)			(23,382)								(37,003)	16
	C. General Administration													
17	Administrative	(4,306)		18,640	(77,221)	(343,550)		4,831					(401,606)	17
18	Directors Fees													18
19	Professional Services	(52,192)		(101,452)	(12,170)	14,606		19					(151,189)	19
20	Fees, Subscriptions & Promotions	(26,768)		94	187			12					(26,475)	20
21	Clerical & General Office Expenses	(99,951)		59,130	4,792			18					(36,011)	21
22	Employee Benefits & Payroll Taxes	(8,373)											(8,373)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(90)		136	308								354	24
25	Other Admin. Staff Transportation			765	3,372								4,137	25
26	Insurance-Prop.Liab.Malpractice			504	713			37					1,254	26
27	Other (specify):*			10,788	9,228	13,031		545					33,592	27
28	**TOTAL General Administration**	(191,680)		(11,395)	(70,791)	(315,913)		5,462					(584,317)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(223,400)		(8,886)	(106,982)	(344,564)		5,462					(678,370)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	101,745	354,397	2,997	4,191								463,330	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(92,213)	1,358,572	1,329	3,904								1,271,592	32
33	Real Estate Taxes			1,823	3,254								5,077	33
34	Rent-Facility & Grounds		(1,564,605)										(1,564,605)	34
35	Rent-Equipment & Vehicles			3,102	5,234			292					8,628	35
36	Other (specify):*		19,385										19,385	36
37	**TOTAL Ownership**	9,532	167,749	9,251	16,583			292					203,407	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*		50,261										50,261	43
44	**TOTAL Special Cost Centers**		50,261										50,261	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(213,868)	218,010	365	(90,399)	(344,564)		5,754					(424,702)	45

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		See Attached	Lincolnwood	Building
				Elmwood Care Bldg, LLC		Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,564,605	Elmwood Building, LLC	100.00%	$	$ (1,564,605)	1
2	V	30	Depreciation		Elmwood Building, LLC	100.00%	354,397	354,397	2
3	V	32	Interest Expense		Elmwood Building, LLC	100.00%	1,358,572	1,358,572	3
4	V	36	Amortization		Elmwood Building, LLC	100.00%	6,667	6,667	4
5	V	36	Assignment Fee Expense		Elmwood Building, LLC	100.00%	12,718	12,718	5
6	V	43	Additional Rent Expense		Elmwood Building, LLC	100.00%	50,261	50,261	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,564,605			$ 1,782,615	$ * 218,010	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 809	$ 809	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	976	976	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	724	724	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	18,640	18,640	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,118	2,118	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	94	94	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	59,130	59,130	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	136	136	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	765	765	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	504	504	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	10,788	10,788	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,997	2,997	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,329	1,329	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,823	1,823	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,102	3,102	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	103,570	PREFERRED BOOKKEEPING	100.00%		(103,570)	32
33	V	19	COMPUTER	5,880	PREFERRED BOOKKEEPING	100.00%	5,880		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 109,450			$ 109,815	$ * 365	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,434	$ 1,434	15
16	V	6	REPAIRS AND MAINT.	22,056	S.I.R. MANAGEMENT, INC.	100.00%	7,035	(15,021)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	778	778	17
18	V	10	NURSING	48,516	S.I.R. MANAGEMENT, INC.	100.00%	21,188	(27,328)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,946	3,946	19
20	V	17	ADMINISTRATIVE	85,968	S.I.R. MANAGEMENT, INC.	100.00%	8,747	(77,221)	20
21	V	19	PROFESSIONAL FEES	19,848	S.I.R. MANAGEMENT, INC.	100.00%	7,678	(12,170)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	187	187	22
23	V	21	CLERICAL & GENERAL	24,996	S.I.R. MANAGEMENT, INC.	100.00%	29,788	4,792	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	308	308	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,372	3,372	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	713	713	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,228	9,228	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,191	4,191	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,904	3,904	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,254	3,254	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,234	5,234	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 201,384			$ 110,985	$ * (90,399)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 24,996	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,193	$ (18,803)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,165	1,165	16
17	V	17	ADMIN./LEGAL SALARIES	415,405	S.I.R. MANAGEMENT, INC.	100.00%	71,855	(343,550)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	14,606	14,606	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	13,031	13,031	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	28,512	S.I.R. MANAGEMENT, INC.	100.00%	18,736	(9,776)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,658	3,658	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	15,000	S.I.R. MANAGEMENT, INC.	100.00%	8,454	(6,546)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,651	1,651	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 483,913			$ 139,349	$ * (344,564)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 123,138	$ 123,138	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	123,138	CCS EMPLOYEE BENEFIT GROUP	100.00%		(123,138)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 123,138			$ 123,138	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 19	$ 19	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12	12	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	18	18	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	37	37	18
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	292	292	19
20	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%		(4,320)	20
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	9,239	9,239	21
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	545	545	22
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	(88)	(88)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,320			$ 10,074	$ * 5,754	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lori Barrish	Shareholder	Administrative	2.04%	NONE	40	100.00%	Salary	$ 84,112	17-1	1
2	Bryan Barrish	Shareholder	Administrative	28.27%	See Attached	4.52	10.04%	Alloc SIR	18,876	17-7	2
3	Mike Giannini	Shareholder	Administrative	22.96%	See Attached	4.52	10.04%	Alloc SIR	19,003	17-7	3
4	Louise Bergthold	Shareholder	Administrative	4.90%	See Attached	6.22	11.31%	Alloc SIR	20,864	17-7	4
5	Joey Abramchik	Shareholder	Administrative	2.04%	See Attached	5.65	11.30%	Alloc SIR	14,606	17-7	5
6	Tom Winter	Shareholder	Administrative	1.43%	See Attached	7.19	11.98%	Alloc SIR	18,640	17-7	6
7	Stuart Sikes	Shareholder	Administrative	0.82%	See Attached	4.52	11.30%	Alloc SIR	12,279	17-7	7
8	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	4.52	11.30%	Alloc SIR	8,330	17-7	8
9	Arturo Rominiquit	Relative	Clerical		See Attached	4.80	12.00%	Alloc SIR	2,716	21-7	9
10	Nenita Guzman	Relative	Dietary		See Attached	5.65	11.30%	Alloc SIR	6,193	1-7	10
11	Eric Rothner	Shareholder	Administrative	20.83%	See Attached	0.71	1.00%	Alloc SIR	1,741	17-7	11
12											12
13								TOTAL	$ 207,360		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	863,792	11	$ 6,745	$	103,570	$ 809	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	863,792	11	8,137		103,570	976	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	863,792	11	6,035		103,570	724	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	863,792	11	155,464	155,464	103,570	18,640	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	863,792	11	17,663		103,570	2,118	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	863,792	11	788		103,570	94	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	863,792	11	493,157	432,172	103,570	59,130	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	863,792	11	1,135		103,570	136	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	863,792	11	6,379		103,570	765	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	863,792	11	4,205		103,570	504	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	863,792	11	89,973		103,570	10,788	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	863,792	11	24,993		103,570	2,997	12
13	32	INTEREST	BOOK./ACCNT.INCOME	863,792	11	11,085		103,570	1,329	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	863,792	11	15,206		103,570	1,823	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	863,792	11	25,868		103,570	3,102	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,880	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,833	$ 587,636		$ 109,815	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	$ 12,680	$	71,178	$ 1,434	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	71,178	7,035	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		71,178	778	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	71,178	21,188	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		71,178	3,946	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	71,178	8,747	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		71,178	7,678	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		71,178	187	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	71,178	29,788	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		71,178	308	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	629,428	10	29,820		71,178	3,372	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		71,178	713	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		71,178	9,228	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		71,178	4,191	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		71,178	3,904	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		71,178	3,254	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		71,178	5,234	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 981,450	$ 522,555		$ 110,985	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	$ 54,767	$ 54,767	71,178	$ 6,193	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		71,178	1,165	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	629,428	10	635,411	635,411	71,178	71,855	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	629,428	10	129,159		71,178	14,606	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	629,428	10	$ 115,229	$	71,178	$ 13,031	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 11,413	$		$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	28,512	18,736	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	$ 28,377	$	28,512	$ 3,658	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	70,679	70,679	15,000	8,454	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	13,799		15,000	1,651	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,272,944	$ 964,662		$ 139,349	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 123,138	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 123,138	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 430	$	4,320	$ 19	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	400		4,320	18	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	813		4,320	37	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,493		4,320	292	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	96,000	9			4,320		6
7	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	79,839	79,839	5	9,239	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		5	545	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)			(88)	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,413	$ 79,839		$ 10,074	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	S.I.R. Management	X		WORKING CAPITAL				920,000			46,907	6
7	Horton Insurance Agency		X	INSURANCE	$211	01/04/00					1,687	7
8												8
9	TOTAL Facility Related				$211		$	$ 920,000			$ 48,594	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										1,271,595	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,271,595	14
15	TOTALS (line 9+line14)						$	$ 920,000			$ 1,320,189	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocation Elmwood Building	X		Capitalized Lease			$	$			$ 1,358,572	1
2	Interest Income	X									(92,213)	2
3	Allocation Preferred Bkkpg	X									1,329	3
4	Allocation SIR Mgmt	X									3,907	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,271,595	21

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	475,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	440,097	2
3. Under or (over) accrual (line 2 minus line 1).	$	(35,403)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	448,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	39,539	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 149,534 **For** 19 95-97 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	452,336	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	407,376	8
	1997	418,058	9
	1998	427,944	10
	1999	461,646	11
	2000	435,020	12

2001 Tax Accrual=actual tax x 1.03; 435,020 X 1.03=448,200

Allocations-S.I.R. Mgmt.-$3,254 Preferred Bookkeeping-$1,823

Refund is not adjusted since it relates to 95-97; non rate setting years

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ELMWOOD CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-25-323-003-000	Building	$ 119,911.67	$ 119,911.67
2.	12-25-323-004-000	Building	$ 120,029.17	$ 120,029.17
3.	12-25-323-005-000	Building	$ 187,891.41	$ 187,891.41
4.	12-25-324-001-000	Building	$ 5,133.22	$ 5,133.22
5.	12-25-324-002-000	Building	$ 2,054.49	$ 2,054.49
6.	Allocation of 2000 Real EstateTaxes	S.I.R. Properties (See Attached)	$ 64,023.09	$ 5,222.40
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 499,043.05	$ 440,242.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,565 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1993	$ 627,991	1
2			1998	100,000	2
3	TOTALS			$ 727,991	3

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20	6,460	6,460	53,525	9
10	Various			1994	49,738		20	2,487	2,487	18,759	10
11	Various			1995	167,102		20	8,357	8,357	54,604	11
12	Various			1996	136,090		20	6,804	(6,804)	36,488	12
13	Various			1997	16,180		20	809	809	3,678	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		12,027,152	309,455		344,673	35,218	2,306,373	68
69	Financial Statement Depreciation			74,726			(74,726)		69
70	TOTAL (lines 4 thru 69)		$ 12,525,465	$ 384,181		$ 369,590	$ (28,199)	$ 2,473,427	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,525,465	$ 384,181		$ 369,590	$ (14,591)	$ 2,473,427	1
2	REPLACEMENT WINDOWS	1998	3,890		20	195	195	748	2
3	IRON RAILINGS	1998	2,925		20	146	146	560	3
4	FLOORING	1998	27,482		20	1,374	1,374	5,267	4
5	ELEVATOR WORK	1998	3,632		20	182	182	698	5
6	ROOF WORK	1998	2,200		20	110	110	413	6
7	NURSES STATION WORK	1998	27,371		20	1,369	1,369	5,020	7
8	FLOORING-CARPET	1998	3,745		20	187	187	701	8
9	TILES	1998	4,157		20	208	208	745	9
10	HAND RAILS	1998	19,827		20	1,983	1,983	7,106	10
11	TUCKPOINTING	1998	12,500		20	625	625	2,240	11
12	BLINDS	1998	1,336		20	67	67	240	12
13	BLINDS	1998	9,051		20	453	453	1,623	13
14	HAND RAILS	1998	5,636		20	564	564	1,833	14
15	CARPETING	1998	3,090		20	155	155	491	15
16	REMODEL N.STATION	1998	8,507		20	425	425	1,523	16
17	HEATING LINE	1998	1,495		20	75	75	281	17
18	DRAPERIES	1998	3,958		20	198	198	677	18
19	PAINTING &DECORATING	1998	4,233		20	212	212	707	19
20	COMPRESSOR	1998	3,620		20	181	181	618	20
21	PAINTING &DECORATING	1998	3,966		20	198	198	644	21
22	ELECTRICAL WIRING	1998	1,642		20	82	82	260	22
23	MIXING VALVE	1998	1,127		20	56	56	224	23
24	WATER VALVES	1998	1,416		20	71	71	278	24
25	COMPRESSOR	1998	1,349		20	67	67	223	25
26	GLASS DOOR	1998	3,756		20	188	188	376	26
27	ELEVATOR WORK	1999	2,895		20	145	145	435	27
28	FIRE DOORS	1999	3,476		20	174	174	508	28
29	PAINT & WALLPAPER	1999	14,333		20	717	717	1,912	29
30	HVAC COMPRESSOR	1999	10,891		20	545	545	1,408	30
31	POARKING LOT	1999	24,171		20	1,209	1,209	3,023	31
32	HVAC WORK	1999	3,078		20	154	154	385	32
33	ELEVATOR WORK	1999	10,895		20	545	545	1,363	33
34	TOTAL (lines 1 thru 33)		$ 12,757,115	$ 384,181		$ 382,450	$ (1,731)	$ 2,515,957	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,757,115	$ 384,181		$ 382,450	$ (1,731)	$ 2,515,957	1
2	LANDSCAPING	1999	17,036		20	852	852	2,059	2
3	FENCING	1999	3,458		20	173	173	418	3
4	PATIO WORK	1999	11,600		20	580	580	1,353	4
5	S.I.R. ALLOCATION	1999	13,707		20	685	685	1,484	5
6	QUARRY TILE	1999	1,309		20	65	65	135	6
7	DISCHGE DOOR	1999	1,435		20	72	72	150	7
8	HVAC	1999	2,728		20	136	136	306	8
9	DRIER EXHAUST	1999	1,750		20	88	88	191	9
10	CUBICLE CURTAINS	1999	1,009		20	50	50	117	10
11	MURAL	1999	800		20	40	40	117	11
12	DUCT CLEANING	1999	2,668		20	133	133	366	12
13	INTERIOR SIGNS	1999	3,956		20	198	198	561	13
14	CONCRETE PIPES	1999	3,600		20	180	180	525	14
15	SPRINKLER	1999	3,224		20	161	161	322	15
16	FIRE PANEL	2000	8,650		20	433	433	794	16
17	HVAC WORK	2000	9,373		20	469	469	743	17
18	HVAC WORK	2000	12,416		20	621	621	932	18
19	ELECTRICAL WIRING	2000	7,700		20	385	385	642	19
20	ELECTRICAL WIRING	2000	4,800		20	240	240	340	20
21	SEWER WORK	2000	2,800		20	140	140	222	21
22	JRC SEWER	2000	2,250		20	113	113	151	22
23	FREEZER WORK	2000	2,455		20	123	123	164	23
24	DOORS	2000	4,012		20	201	201	251	24
25	BEARING ASSEMBLY	2000	1,242		20	62	62	88	25
26	1/12 HP MOTOR	2000	839		20	42	42	60	26
27	SEWER	2000	850		20	43	43	61	27
28	TILE	2000	1,371		20	69	69	86	28
29	DRYWALL	2000	1,085		20	54	54	99	29
30	MIXING VALVE	2000	753		20	38	38	54	30
31	PUMP	2000	1,778		20	89	89	119	31
32	PAINT	2000	688		20	34	34	45	32
33	WIRING	2000	1,226		20	61	61	81	33
34	TOTAL (lines 1 thru 33)		$ 12,889,683	$ 384,181		$ 389,080	$ 4,899	$ 2,528,993	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,889,683	$ 384,181		$ 389,080	$ 4,899	$ 2,528,993	1
2	BLOCK HEATER	2000	1,044		20	52	52	56	2
3	PLUMBING	2000	675		20	34	34	37	3
4	PAINTING	2000	650		20	33	33	36	4
5	PRIVACY CURTAINS	2000	926		20	46	46	58	5
6	ROOFING	2001	46,330		20	2,317	2,317	2,317	6
7	SEWER WORK	2001	3,800		20	111	111	111	7
8	ROOFING	2001	12,940		20	270	270	270	8
9	WCT WORK	2001	26,148		20	109	109	109	9
10	HOT WATER-PIPING	2001	2,519		20	126	126	126	10
11	COMPRESSOR-VALVES	2001	1,323		20	66	66	66	11
12	CONCRETE CHIMNEY	2001	2,575		20	129	129	129	12
13	PULLEY & BELT	2001	1,247		20	62	62	62	13
14	THERMOCOUPLER	2001	1,528		20	76	76	76	14
15	HEX BOLT	2001	1,380		20	69	69	69	15
16	WALLPAPER BORDER	2001	2,996		20	150	150	150	16
17	CONCRETE PATION&BASIN	2001	3,800		20	190	190	190	17
18	CUSTOM DIFFUSER	2001	1,068		20	53	53	53	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,000,632	$ 384,181		$ 392,973	$ 8,792	$ 2,532,908	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1994		$ 11,931,834	$ 305,944	35	$ 340,910	$ 34,966	$ 2,281,832	4
5			1993		16,931	538	35	484	(54)	4,112	5
6			1993		30,217	959	35	863	(96)	7,338	6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	Allocation Preferred Bookkeeping			1997	21,144	473	20	1,057	584	5,084	11
12	Allocation Preferred Bookkeeping			1999	168	32	20	8	24	21	12
13	Allocation Preferred Bookkeeping			2000	1,061	-	20	53	53	75	13
14											14
15	Allocation S.I.R. Management			1993	12,978	361	20	655	294	5,770	15
16	Allocation S.I.R. Management			1994	40	-	20	4	4	30	16
17	Allocation S.I.R. Management			1995	297	-	20	15	15	95	17
18	Allocation S.I.R. Management			1999	1,410	67	20	71	4	156	18
19	Allocation S.I.R. Management			2000	851	148	20	43	(105)	72	19
20											20
21	Allocation S.I.R. Management-S.I.R. Properties			1999	3,829	383	20	191	(192)	479	21
22	Allocation S.I.R. Management-S.I.R. Properties			1998	1,830	183	20	91	(92)	320	22
23	Allocation S.I.R. Management-S.I.R. Properties			1997	114	11	20	6	(5)	31	23
24	Allocation S.I.R. Management-S.I.R. Properties			1994	288	7	20	14	7	108	24
25	Allocation S.I.R. Management-S.I.R. Properties			1993	490	13	20	25	12	208	25
26											26
27	Allocation S.I.R. Properties-Preferred Bookkeeping			1999	2,145	215	20	107	(108)	268	27
28	Allocation S.I.R. Properties-Preferred Bookkeeping			1998	1,025	103	20	51	(52)	179	28
29	Allocation S.I.R. Properties-Preferred Bookkeeping			1997	64	6	20	3	(3)	18	29
30	Allocation S.I.R. Properties-Preferred Bookkeeping			1994	161	4	20	8	4	60	30
31	Allocation S.I.R. Properties-Preferred Bookkeeping			1993	275	8	20	14	6	117	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,027,152	$ 309,455		$ 344,673	$ 35,266	$ 2,306,373	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,452,518	$ 51,982	$ 144,593	$ 92,611	10	$ 1,133,064	71
72	Current Year Purchases	7,621	145	487	342	10	487	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,460,139	$ 52,127	$ 145,080	$ 92,953		$ 1,133,551	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,188,762	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 436,308	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 538,053	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 101,745	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,666,459	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 5,155 Description: Toshiba Copier -$2715; Ice Maker-$1395-Alloc SIR mgmt-$267-Alloc Pref.Bkkpng-$778
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	98 Chevy Van	$ 440	$ 3,520	17
18	Alloc.Pref.Bkkg.			2,323	18
19	Alloc.S.I.R.			4,968	19
20	Alloc. ECM			292	20
21	TOTAL		$ 440	$ 11,103	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 70,592	$		$ 70,592	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			30,082			30,082	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			105,502			105,502	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				71,793		71,793	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					2,305	31,281		33,586	13
14	TOTAL			$		$ 208,481	$ 103,074		$ 311,555	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 107,817	$ 107,917	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,451,448	1,451,448	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	19,094	19,094	6
7	Other Prepaid Expenses	1,012	1,012	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	485,258	485,258	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,064,629	$ 2,066,769	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		727,991	13
14	Buildings, at Historical Cost		11,931,834	14
15	Leasehold Improvements, at Historical Cost	481,544	481,544	15
16	Equipment, at Historical Cost	1,017,483	1,752,483	16
17	Accumulated Depreciation (book methods)	(1,009,661)	(4,026,493)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	2,765	172,650	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 492,131	$ 11,040,009	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,556,760	$ 13,106,778	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 164,010	$ 164,010	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68,700	159,757	28
29	Short-Term Notes Payable	920,000	920,000	29
30	Accrued Salaries Payable	261,424	261,424	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,148	17,148	31
32	Accrued Real Estate Taxes(Sch.IX-B)	448,200	448,200	32
33	Accrued Interest Payable	1,194	1,194	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,900	5,900	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,886,576	$ 1,977,633	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule		13,601,257	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,601,257	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,886,576	$ 15,578,890	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 670,184	$ (2,472,112)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,556,760	$ 13,106,778	48

*(See instructions.)

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 833,803	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 833,803	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(163,619)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (163,619)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 670,184	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,122,162	1
2	Discounts and Allowances for all Levels	(451,089)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,671,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	529,215	6
7	Oxygen	5,185	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 534,400	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	65,494	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,708	19
20	Radiology and X-Ray	12,270	20
21	Other Medical Services	19,857	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 118,329	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	92,213	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 92,213	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	192,790	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 192,790	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,608,805	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,344,082	31
32	Health Care	3,010,332	32
33	General Administration	1,869,043	33
	B. Capital Expense		
34	Ownership	2,103,275	34
	C. Ancillary Expense		
35	Special Cost Centers	311,555	35
36	Provider Participation Fee	134,137	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,772,424	40
41	**Income before Income Taxes (line 30 minus line 40)****	(163,619)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (163,619)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,806	2,148	$ 89,163	$ 41.51	1
2	Assistant Director of Nursing	1,797	2,110	54,232	25.70	2
3	Registered Nurses	43,835	46,470	1,063,105	22.88	3
4	Licensed Practical Nurses	8,067	8,657	164,042	18.95	4
5	Nurse Aides & Orderlies	88,055	92,531	855,160	9.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,709	9,151	80,247	8.77	8
9	Activity Director	2,028	2,149	32,961	15.34	9
10	Activity Assistants	8,348	8,630	53,139	6.16	10
11	Social Service Workers	6,355	6,591	64,132	9.73	11
12	Dietician	1,854	2,325	36,609	15.75	12
13	Food Service Supervisor					13
14	Head Cook	9,709	10,166	96,845	9.53	14
15	Cook Helpers/Assistants	16,896	18,590	152,117	8.18	15
16	Dishwashers					16
17	Maintenance Workers	3,978	4,184	41,379	9.89	17
18	Housekeepers	28,477	30,088	200,514	6.66	18
19	Laundry	9,885	10,195	62,216	6.10	19
20	Administrator	1,821	2,086	84,112	40.32	20
21	Assistant Administrator	2,109	2,294	55,798	24.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,724	8,140	91,456	11.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,875	4,178	57,838	13.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,329	270,683	$ 3,335,065 *	$ 12.32	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 15,000	01-03	35
36	Medical Director	96	6,900	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	Monthly	48,516	10-03	38
39	Pharmacist Consultant	60	1,800	10-03	39
40	Physical Therapy Consultant	216	8,622	10a-03	40
41	Occupational Therapy Consultant	151	6,055	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		520	10a-03	43
44	Activity Consultant	44	2,100	11-03	44
45	Social Service Consultant	106	5,393	12-03	45
46	Other(specify)				46
47	Director of Food Services	Monthly	24,996	01-03	47
48					48
49	TOTAL (lines 35 - 48)	769	$ 123,934		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,447	$ 152,477	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,935	40,338	10-03	52
53	TOTAL (lines 50 - 52)	6,382	$ 192,815		53

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Barrish	Administrator	2%	$ 84,112
Lori Fernanado-04/13/01-12/31/01	Asst Admin		40,268
Margaret Mahoney-01/01/01-04/12/01	Asst Admin		15,530
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 139,910

B. Administrative - Other

Description	Amount
Management Fees-Director Adm Services	$ 30,876
Administrative Charges-Ancillary	55,092
Management Fees	415,405
Owners Council-Management Fee	4,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 505,693
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 26,696
Preferred Bookkeeping	Accounting	21,250
Preferred Bookkeeping	Computer	5,880
Personnel Planners	Unemployment Consulting	1,885
Preferred Bookkeeping	Bookkeeping Services	82,320
Michael Best & Friedrich, LLC	Legal	28,202
Schwartz & Freeman	Legal	31,137
Stone, Mcguire & Benjamin	Legal	11,353
Katz Randall Weinberg	Legal	7,420
Cambria	Legal	1,125
S.Sikes/McCorkle	Legal	200
See Attached		60,706
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 278,175

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,567
Unemployment Compensation Insurance	30,367
FICA Taxes	247,898
Employee Health Insurance	79,964
Employee Meals	35,872
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	79,538
Employe Benefits	16,449
TOTAL (agree to Schedule V, line 22, col.8)	$ 527,655

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	34,614
Health Care Worker Background Check	
(Indicate # of checks performed 152)	1,067
Advertising	14,431
Licenses & Permits	1,212
Yellow Page Advertising	11,302
Dues & Subsriptions	9,555
Trust Fees	150
See Attached	86
Less: Public Relations Expense	
Non-allowable advertising	(14,431)
Yellow page advertising	(11,302)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,684

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	950
Allocation S.I.R.	444
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,394

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	1996	$ 34,222	3 yrs	$ 11,407	$ 5,704	$	$	$	$	$	$	$
2	Painting & Decorating	1997	8,074	3 yrs	2,692	2,692	1,346						
3	Painting & Decorating	1998	9,860	3 yrs	1,643	3,287	3,287	1,643					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 52,156		$ 15,742	$ 11,683	$ 4,633	$ 1,643	$	$	$	$	$

Facility Name & ID Number ELMWOOD CARE # 0040410 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council on LTC-$9498.64**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,506** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **134,137**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **36,157** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%-In 1**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees